CALIFORNIA CABG OUTCOMES REPORTING PROGRAM
Surgeon Certification Form

OSH-CCORP 415 (Revised 05/05)

Healthcare Quality and Analysis Division
818 K Street, Room 200
Sacramento, California 95814
(916) 322-9700 FAX (916) 445-7534

Surgeon's name: _____ _____ _____
(First) *(Middle Initial)l* *(Last)*

California Physician License Number: _____

Hospital name: _____

Facility Identification Number: _____

Report period: *From:* _____ *To:* _____
(Month) (Day) (Year) *(Month) (Day) (Year)*

Number of records included in this report: _____

Statement of Certification

I, _____, affirm that the cases assigned to me in this
(Name of Surgeon)
California CABG Outcomes Reporting Program report are accurate, and that I have reviewed these data for accuracy and completeness. I also understand that these data, after any corrections or revisions required by the Office of Statewide Health Planning and Development, will be used to compute my risk-adjusted mortality rate for coronary artery bypass graft surgery, and that the Office of Statewide Health Planning and Development will assign data elements with invalid or missing values the lowest risk value as observed in the most current risk-adjustment model for predicting mortality.

Name: _____

Signature: _____ Dated: _____

Address: _____

Telephone: _____

E-mail: _____